Connecticut Department of Social Services
Making a Difference

Testimony before the Human Services Committee
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Good morning, Senator Slossberg and Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am pleased to be before you today to testify on several bills raised on behalf of the Department. In addition, I offer written remarks on several other bills on today's agenda that impact the Department.

Bills Raised on Behalf of DSS:

H.B. No. 5443 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE FOR CERTAIN OVER-THE-COUNTER DRUGS.

This proposal, while adding very modest additional Medicaid over-the-counter drug coverage, is necessary to comply with federal requirements for the Medicaid expansion. This change is necessary to allow coverage of over-the-counter drugs that are required to be included in the benefits package for the Medicaid expansion to non-disabled, non-elderly adults without dependent children (Medicaid Coverage for the Lowest Income Populations or HUSKY D) earning up to 138% of the federal poverty level. At this time, the only additional over-the-counter drugs that would be required to be covered by this change are those listed in the U.S. Preventive Services Task Force A and B recommendations. Specifically, those drugs include only: (1) low-dose aspirin to prevent cardiovascular disease for men ages 45 to 79 years of age and women ages 55 to 79 years of age when the potential benefit outweighs the potential harm; and (2) folic acid for women who are planning or are capable of becoming pregnant (folic acid is already covered for women who are pregnant).

The Medicaid expansion is governed by federal law, pursuant to section 2001 of the Affordable Care Act. Beginning January 1, 2014, federal law requires the benefit package provided to individuals in the Medicaid expansion to offer ten Essential Health Benefits. These requirements apply both to newly eligible individuals under the Medicaid expansion and also to individuals previously included in Connecticut's partial expansion of Medicaid to low-income adults beginning in April 2010, pursuant to 42 U.S.C. § 1396a(k)(2).

Connecticut's Medicaid program already covers the vast majority of the preventive services included in those guidelines. The only items not currently covered are the over-the-counter medications recommended for individuals with certain diagnoses in the U.S. Preventive Services Task Force ("USPSTF") recommendations. Those over-the-counter drugs are not currently covered because Conn. Gen. Stat. § 17b-280a, which was adopted in 2010, prohibits such

coverage, except in limited circumstances not applicable to the preventive services requirements. Recognizing that the benefits of this expansion outweigh the costs, as well as the advantages in managing a uniform program from an administrative standpoint, this bill also extends coverage of these drugs to other Medicaid-eligible populations.

We ask for your support of this bill.

H.B. No. 5439 (RAISED) AN ACT CONCERNING MEDICAID BRAND NAME DRUG PRESCRIPTIONS.

This bill seeks to revise the requirements for practitioners utilizing electronic prescriptions to prescribe a brand name drug product as "medically necessary." Section 17b-274 (b) currently requires the prescribing practitioner to follow up with written certification that the brand name drug is medically necessary. As a result, the prescribing practitioner is required to send something in writing to the pharmacy, even though the electronic prescription was meant to replace the need for a written prescription and allow for more efficiency in the provision of medical care to patients.

The electronic prescription system is a secure system, and each physician has a unique log-in and password. Electronic prescriptions allow a provider to send an accurate, error-free, and understandable prescription directly to the pharmacy. During the process of sending a prescription electronically, the prescribing physician can verify eligibility and formulary data for a patient and view medication history for the patient. Electronic prescribing also helps the providers save time and money. Requiring follow-up written notification within 10 days of sending the electronic prescription defeats the purpose of submitting electronic prescriptions and creates unnecessary paperwork. Given the current requirements, many providers may opt to send a written prescription when prescribing brand name medication to avoid the two-step process associated with electronic prescribing.

We ask for your support of this bill.

H.B. No. 5441 (RAISED) AN ACT CONCERNING DIRECT PAYMENT OF RESIDENTIAL CARE FACILITIES.

This bill is intended to improve the process by which DSS makes payments to licensed boarding homes. This improvement is accomplished by permitting the Department to make State Supplement benefit payments directly to boarding homes, instead of through residents. DSS uses a similar model to make payments to nursing facilities on behalf of Medicaid recipients. The current payment process for State Supplement benefits that are owed to a boarding home requires that the benefits pass through the resident and then be paid to the boarding home. This adds an unnecessary extra step in the payment process and frequently results in difficulties when the boarding home is unable to obtain the owed payments from the residents. Residential care homes (RCH) have requested this operational change and the Department believes that it will improve payment accuracy and efficiency.

In addition to allowing the Department to make direct payments, the bill also seeks to address an area of operational inefficiency involving retroactive rate increases -- by requiring RCHs to submit complete and accurate annual rate reports to the Department within 30 days of being notified that they failed to submit a complete and accurate report, or the RCHs will not receive retroactive rate increases. Finally, if a retroactive rate increase results in a current resident of an RCH becoming eligible for State Supplement benefits, the Department will be able to provide the RCH a retroactive payment for the period that the eligible resident was in the RCH, up to a maximum of three months.

Required annual cost reports are frequently not submitted in a timely manner, which often leads to no rate increase or a rate decrease for the RCH. When the required report is finally submitted, the Department calculates a retroactive rate increase. Due to the rate increase, some residents of RCHs who were previously ineligible for boarding home State Supplement benefits may become eligible. This is because eligibility for this State Supplement benefit is directly linked to RCH payment rates. To be eligible for a boarding home payment, it must be determined that the need of the beneficiary exceeds the beneficiary's income. The beneficiary's need is determined by using the daily rate of the RCH plus the personal needs allowance. In order to then calculate the amount owed to an RCH because of a retroactive increase, the Department imputes eligibility for State Supplement benefits for admitted residents back to the effective date of the increase. This process is cumbersome, time-consuming and error-prone.

In order to reduce the need to provide retroactive rate adjustments that date well back into the past, the Department proposes that the RCHs be required to timely submit their annual cost reports in order to obtain retroactive adjustments. The Department will provide a non-compliant RCH with a 30-day opportunity to submit a complete and accurate cost report. If the non-compliant RCH fails to produce the report in that period, then the RCH will not be eligible for a retroactive rate increase. In order to provide certainty to the RCH regarding the level of retroactive payment, the Department proposes that any resident who becomes eligible for benefits as a result of the increase will be determined to have applied for benefits as of the date of admission to the RCH or 90 days prior to application, whichever is more recent. The Department must limit eligibility retroactivity to 90 days, due to Medicaid rules associated with State Supplement benefits.

The Department would like to respectfully request an amendment to this provision and have appended recommended language to our testimony. The purpose is to reflect a more up-to-date definition of "boarding homes" that captures all of the existing facilities. It is our intention to incorporate this definition into the Department's Uniform Policy Manual, and we would ask that the bill be amended for consistency, as well.

We ask for your support of this bill.

S.B. No. 324 (RAISED) AN ACT CONCERNING DEPARTMENT OF SOCIAL SERVICES PROGRAMS.

This bill seeks to make a number of minor and technical changes to the Department's statutes in order to clarify provisions passed in the 2013 legislative session, remove obsolete provisions, and align statutes with current practice.

Section 1 -- seeks to amend the date that the Department must submit the annual Low-Income Energy Assistance Program allocation plan from August 1 to October 1. This change is being requested to reflect current timeframes in which the allocation plan is developed, based on the release of federal block grant allocation amounts and the scheduling of legislative hearings.

Section 2 -- we respectfully request withdrawal of this provision. This section was merely seeking to correct an error from legislation that passed in the previous session in which it was added to wrong statutory section. However, as the Department does not need this language for any administrative purposes, we will not pursue this proposal and respectfully request that it be deleted from the bill.

Section 3 and 4 -- amend sections 89 and 90 of Public Act 13-247 of the 2013 session. This correction was brought to our attention by LCO and OLR after the passage of the public act.

The intent of these provisions was to allow the Department to issue rates lower than those in effect on June 30, 2013, to facilities with interim rate status agreements with the Department. Therefore, language should have been included to make an exception to the language that "no facility shall be issued a rate that is lower than the rate in effect on June 30, 2013." In other words, no facility shall be issued a rate lower than what was in effect June 30, 2013, except for those that would have been due interim rates.

Section 5 -- amends section 17b-408, which describes the process for receiving the report of abuse made under section 17b-407 (Protective Services for the Elderly) and how it must be investigated. Pursuant to legislation establishing the state Department on Aging, section 17b-407 was amended so that "commissioner" now refers to the Commissioner on Aging. However, DSS retained and administers the Protective Services for the Elderly Program and is conducting the investigations outlined in section 17b-408. Therefore, it is necessary to amend section 17b-408 by adding "of Social Services" to clarify that these investigations are being conducted by the Department of Social Services.

Section 6 -- repeals section 17b-239(f), which allows the Department to pay hospitals for administratively necessary days (ANDs) when the client no longer needs acute hospital level of care but the hospital is unable to find an appropriate placement. There are no HIPAA-compliant billing codes for these services, which federal regulations require in order for Medicaid to make payments. In addition, these payments are made on an interim basis and must be cost-settled at the end of the each year, so that the target amount for each discharge and allowable pass-through amounts are calculated and compared to interim payments (meaning they are recouped and thus have no net effect on the payment for an individual's care). This process of issuing interim payment and then later cost-settling the funds creates administrative burdens on the Department. Also, we are currently in the process of restructuring payments to inpatient hospitals utilizing a

Diagnosis-Related Group (DRG) methodology. DRG is a classification system that groups patients based on the procedure, health status, diagnosis, type of treatment, age, and other relevant criteria. Under the payment system, hospitals are paid a set fee for treating patients in a single DRG category. Providing payment for ANDs, which do not reflect services provided at the time of treatment, is inconsistent with the DRG model.

We ask for your support of this bill.

S.B. No. 252 (RAISED) AN ACT CONCERNING THE OFFICE OF CHILD SUPPORT SERVICES.

This bill changes the name of the Bureau of Child Support Enforcement to the Office of Child Support Services to better reflect the nature of the services we provide to all parents and caretakers of children.

The name Bureau of Child Support Enforcement is not adequate to fully describe the programs and services Connecticut's lead IV-D agency has to offer the public. These child support services include: case initiation; location of parents; establishment of legal paternity; establishment of financial and medical support orders; and collection, distribution, and disbursement of child support payments in IV-D and non-IV-D cases. The services also include those made available through the John S. Martinez Fatherhood Initiative, which are focused on changing the systems that can improve fathers' abilities to be fully and positively involved in the lives of their children. The name change further reflects this agency's, and the federal child support oversight agency's, evolving integrated approach to serving the whole family, whether intact or not.

We ask for your support of this bill.

S.B. No. 328 (RAISED) AN ACT CONCERNING CAPIAS MITTIMUS ORDERS.

This bill would permit judicial marshals to execute capias mittimus orders using a copy of the original document, as state marshals and special policemen are allowed to do. The expansion of this statute to include judicial marshals would assist in reducing capias mittimus backlogs, and improve child support collections. Providing the capias mittimus order in a timely manner to the judicial marshals at a courthouse where criminal and motor vehicle matters are being heard will increase the likelihood of effecting an arrest and bringing the party before a family support magistrate to address paternity or child support issues.

Approval of this provision is recommended in the final report of the Task Force to Study Methods for Improving the Collection of Past Due Child Support, pursuant to Special Act 13-14.

We ask for your support of this bill.

Other Legislation Impacting the Department:

S.B. No. 322 (RAISED) AN ACT CONCERNING A BEHAVIORAL HEALTH CLEARINGHOUSE.

This proposal seeks to create a centralized repository for available behavioral health services to be located within the Office of the Healthcare Advocate. If the goal of the bill is to create a comprehensive clearinghouse of publicly funded and privately funded behavioral health services, we feel that this has merit and should be explored. While we do not object to this legislation in principle, we would recommend that our sister agencies, the Department of Mental Health and Addiction Services, as the lead agency for adult behavioral health, and the Department of Children and Families, as the lead agency for children's behavioral health, be included in any discussions about where the clearinghouse should reside. In addition, it is our hope that this initiative would not be redundant of or impact any services already being done by 2-1-1 Infoline, the state's contracted informational and referral partner.

S.B. No. 323 (RAISED) AN ACT CONCERNING CAPITAL EXPENDITURES AT RESIDENTIAL CARE HOMES.

This bill would allow DSS to reimburse Residential Care Home (RCH) providers for "land, building or non-movable equipment, repair, maintenance or improvement" to the facility that cost $10,000 or less per year. The reimbursement would be included in the fair rent component of the RCH rate for five years or less, depending on the useful life of the improvements.

DSS does not oppose the general concept of the bill, but "maintenance" activities are not a cost that can be capitalized and, as such, references to maintenance activities should be removed from the bill. The Department believes this change will only standardize the useful life to five years for costs of $10,000 or less, and that any additional costs would be negligible if "maintenance" is removed.

H.B. No. 5444 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE OF CHIROPRACTIC SERVICES.

This proposal requires the Department to add chiropractic services to the Medicaid State Plan as an optional service. There are currently no funds included in the Governor's recommended budget adjustments to support this addition; therefore, the department must oppose it.

H.B. No. 5440 (RAISED) AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS.

This bill would allow emergency department (ED) physicians to enroll independently as Medicaid providers, thereby qualifying to be directly reimbursed for professional services provided to Medicaid recipients in hospital emergency departments. Under this legislation, physicians would bill and be paid using applicable Current Procedural Terminology (CPT) codes, rather than the all-inclusive Revenue Center Codes (RCC) currently paid to hospitals and

which includes the physician's reimbursement. Such reimbursement change under this bill would expose the state to significant additional costs in several ways.

First, any additional procedures performed and billed by the physician would be an added cost to the state, whereas the global RCC includes the cost of any procedures. For example, the hospital would be paid no more than the standard visit fee if an emergency physician sets a fractured arm under an RCC. In contrast, an independently enrolled emergency physician would be paid for the visit and for the setting of the fracture. Unfortunately, the Department is limited in its ability to predict fiscal impact of procedures performed because we do not capture these extra procedures in claims under the current methodology. We are concerned, however, that paying separately for these procedures will create a financial incentive to perform more of them.

Second, payment for professional services for Medicaid recipients admitted to hospitals as inpatients on the same day the emergency services are provided are currently rolled into the hospital's reimbursement for the day of admission. If ED physicians' fees are paid separately, these fees would be an added expense to the state.

Third, the professional fees for many patients admitted for observation, which is frequently provided in the emergency department or in a nearby area staffed by the emergency department, would also represent an additional cost to the state, particularly since the fees paid to the hospital will not change.

Finally, the state does not pay an additional professional fee for urgent care provided in the ED, but rather includes this fee in the urgent care RCC. Any professional fees associated with these services would also be new state expenses.

Although the language of this legislation holds hospitals harmless and has a provision for cost neutrality, we believe that this proposal will instead result in significant additional costs to the state. RCCs are set for each hospital based upon their cost reports, which include the professional costs. Paying ED physicians separately without adjusting the RCC accordingly would result in the state paying twice for the same service.

Alternatively, to ensure cost neutrality and hold the hospital harmless, the current emergency department professional fee would need to be adjusted downward to account for the claims for the same-day admissions and observation stays. In addition, since the current volume of procedures is unclear and the future volume will likely grow due to the added financial incentive to perform them, the Department may need to pay only the adjusted professional fees for the visits and not the procedures.

Last year, at the direction of the Department, our contractor (Mercer) completed an analysis of the possible costs of this proposal. Based on their analysis and using two different modeling option, the estimated impact could be anywhere from $1 million to $9 million.

In addition, the U.S. Centers for Medicare and Medicaid Services advised the Department that were we to unbundle any hospital rate, we would be required to do so for all other bundled

hospital rates. Based on this guidance, we estimate the cost implications of unbundling all hospital rates to be at least $25 million.

Given that the Department is currently in the process of replacing the current method of reimbursement with Diagnosis-Related Groups (DRGs) for inpatient services and Ambulatory Payment Classification (APC) for outpatient services, additional changes as required in this bill are not recommended at this time.

For all of these reasons, DSS opposes this legislation.

H.B. No. 5446 (RAISED) AN ACT CONCERNING THE PREVENTION OR ELIMINATION OF DOUBLE CHILD CARE SUBSIDIES.

This bill would prohibit the Department from providing a child care subsidy payment to a provider for any time period for which the Department of Children and Families may have made child care payments on behalf of the recipient. It is our understanding that the intent of this bill is to ensure that providers are not receiving double payments from two separate agencies for the same recipient when a Care 4 Kids eligibility determination is made and granted retroactively. While we understand the intent of this legislation, there are already administrative efforts underway by our Care 4 Kids contractor, United Way of Connecticut, to address this specific issue. We urge the committee to allow United Way the time to address this through administrative means, as opposed to legislation.

Thank you for the opportunity to testify on these bills today. My staff and I would be happy to answer any questions that you may have.

DSS Recommended Amendment to HB 5441

Insert the following as Section 1 and renumber subsequent sections accordingly:

> Section 1. (*Effective from passage*) As used in sections 17b-83 and 17b-601 of the Connecticut General Statutes, as amended by this act, "rated housing facility" means (1) a boarding facility or home licensed by the Department of Developmental Services, the Department of Mental Health and Addiction Services, or the Department of Children and Families; or (2) the facility established by New Horizons, Inc. pursuant to section 19a-507, provided that any such home or facility has been approved by the Department of Social Services to receive state supplement payments in accordance with section 17b-600.

Strike references in Section 1 and Section 2 of Raised Bill 5441 to "a state-operated facility, as defined in section 17a-458, a boarding house, as defined in section 47a-50" and replace with "a rated housing facility as defined in Section 1 of this act"